Schedule 13
Change Request for FY 08-09 Budget Request Cycle

	Decision Item FY 08-09 ☐	Base Reduction Item FY 08-09 ☐	Supplemental FY 07-08 ☑	Budget Request Amendment FY 08-09 ☑
Request Title:	Federal Funds Match for Local Government Provider Fees			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-17, BA-11	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	0	0	10,211,350	10,211,350	0	0	0	5,205,696	5,205,696	5,205,696
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	5,105,675	5,105,675	0	0	0	2,602,848	2,602,848	2,602,848
	FF	0	0	5,105,675	5,105,675	0	0	0	2,602,848	2,602,848	2,602,848
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments (new line item)	Total	0	0	4,225,858	4,225,858	0	0	0	2,154,322	2,154,322	2,154,322
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	2,112,929	2,112,929	0	0	0	1,077,161	1,077,161	1,077,161
	FF	0	0	2,112,929	2,112,929	0	0	0	1,077,161	1,077,161	1,077,161
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments (new line item)	Total	0	0	5,985,492	5,985,492	0	0	0	3,051,374	3,051,374	3,051,374
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	2,992,746	2,992,746	0	0	0	1,525,687	1,525,687	1,525,687
	FF	0	0	2,992,746	2,992,746	0	0	0	1,525,687	1,525,687	1,525,687

Letternote revised text: 1: (new) the Cash Funds Exempt shall be from local government provider fees created in Section 29-28-103 (1), C.R.S.

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-17, BA-11
Change Request Title:	Federal Funds Match For Local Government Provider Fees

SELECT ONE (click on box):

☐ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☒ Supplemental Request FY 07-08
☒ Budget Request Amendment FY 08-09

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:
☐ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☒ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This Request seeks to obtain and record matching federal funds for local government inpatient and outpatient hospital payments. The total funds request consists of cash funds exempt and federal funds totaling $10,211,350 in FY 07-08 and $5,205,696 in FY 08-09. Pursuant to Senate Bill (S.B.) 06-145, local governments may impose a fee on non-government or private hospital providers for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs.

Background and Appropriation History: During the 2006 legislative session, the General Assembly passed S.B. 06-145, which became law on May 5, 2006 without the Governor's signature, allowing a local government to impose a fee on private hospital providers within their jurisdictions that provide inpatient and/or outpatient services for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs.

The Department determined this legislation to have conditional fiscal impact in FY 06-07 and FY 07-08 should local governments elect to impose a fee on private hospital providers within their jurisdictions. Moreover, the Department could not predict what assessment

rate would be applied to inpatient and/or outpatient revenues. Additionally, as the single State agency authorized to distribute federal Medicaid funds, the Department was required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services authorizing the reimbursement methodology before federal financial participation is drawn down and provider payments issued.

Since the passage of S.B. 06-145, the Department has developed a reimbursement methodology and submitted two State Plan Amendments (TN 06-013 for Inpatient Hospital Services and TN 06-014 for Outpatient Hospital Services) on September 29, 2006 to the Centers for Medicare and Medicaid Services. At the time of writing this request, only one local government entity — City of Brighton — has informed the Department of their imposition of a provider fee on inpatient and outpatient hospital revenues on their sole private hospital provider, Platte Valley Medical Center.

General Description of Request: This request is a zero General Fund request that seeks to draw down $5,105,675 in matching federal funds using $5,105,675 in cash funds exempt in FY 07-08 and $2,602,848 in federal funds and $2,602,848 in cash funds exempt in FY 08-09. The cash funds exempt will be collected by local governments who elect to impose a fee on private hospital providers within their jurisdictions.

In 2006, the General Assembly passed S.B. 06-145 — "*Concerning the Authority of a Local Government to Impose a Fee on Certain Medical Providers for Purposes of Obtaining Federal Financial Participation under Medicaid for Unreimbursed Medicaid Costs"* — which permits local governments to impose fees on revenues of private hospital providers within their jurisdictions. The local government is required, pursuant to 29-28-103 (2) C.R.S. (2007), to distribute the full amount of funds collected from the imposition of the provider fee and federal financial participation received for eligible unreimbursed Medicaid costs.

When a local government elects to impose a fee on private hospital providers for the purposes of obtaining federal financial participation, it must notify the Department by August 1st of each State fiscal year. To adequately demonstrate its authority, the local

government must also submit to the Department copies of by-laws, charters, and/or ordinances or resolutions promulgating the fee. While the participation by local governments is voluntary, the qualified providers within the jurisdiction of a participating local government are required to participate (29-28-103 (1)(a), C.R.S (2007)).

However, according to the definition of a qualified provider at 29-28-102 (3) C.R.S. (2007), public hospitals are exempt from the imposition of the local government provider fee. Therefore, if there are public hospitals within the jurisdiction of a participating local government, then the Department must request a waiver of the broad-based requirements established under 42 CFR §433.68(c)(2) from the Centers for Medicare and Medicaid Services to exclude the public hospitals from being assessed the provider fee. This regulation establishes that "if a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of local government has jurisdiction." Given the legislative restriction in S.B. 06-145, the Department must request a waiver from the Centers for Medicare and Medicaid Services of the broad-based requirement, pursuant to 42 CFR §433.72(b), to exclude state-owned hospitals within the territorial boundaries of a participating local government from the proposed provider fee. Should the Centers for Medicare and Medicaid Services deny the waiver request, then the provider fee could not be assessed on any provider (private or public) residing within the jurisdiction of that local government.

Based on the State Plan Amendments (TN 06-013 and TN 06-014), the Department will calculate the assessment base of each participating entity for the Local Government Provider Fee using inpatient and/or outpatient revenues less Medicare and Medicaid revenues from the provider's most recent audited Medicare/Medicaid cost report (CMS 2552-96). When necessary, the audited cost report will be inflated forward to the State's request fiscal year using the Consumer Price Index — Urban Wage Earners, Medical Care Index — U.S. City Average.

According to Colorado's Medicaid State Plan, Attachments 4.19-A and 4.19-B, the local government may impose a fee not to exceed 5.5% on the assessment base for inpatient

and/or outpatient hospital revenues. Pursuant to federal Medicaid law, the 5.5% fee limit is effective January 1, 2008 through September 30, 2011.

After the provider's assessment base has been determined, the Department must calculate the Local Government Inpatient/Outpatient Hospital Reimbursement Payment, which includes federal financial participation to participating hospitals within a participating local government's jurisdiction. The federal financial participation for the Local Government Inpatient/Outpatient Hospital Reimbursement Payment is limited by the Medicare Upper Payment Limit.

The upper payment limit is a reasonable estimate of the amount that Medicare would have paid for the Medicaid services provided under Medicaid payment principles. To limit the abuses in the application of upper payment limit requirements, the Centers for Medicare and Medicaid Services revised regulations at 42 CFR §447.272. Effective March 2001, the revised regulations require States to calculate three separate upper payment limits, one for each category of provider: 1) state-owned or operated; 2) non-state government owned or operated; and 3) privately owned or operated. Federal regulations at 42 CFR §447.257 state that federal matching funds are not available for state expenditures that exceed the upper payment limit for any provider category.

The Reimbursement Payment is based on the ratio of the hospital's inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs relative to the total inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs of all participating hospitals located within the jurisdiction of the participating local government. The Department will compute the Local Government Inpatient/Outpatient Hospital Reimbursement Payment for each qualified provider by December 15th of each State fiscal year and report the amounts to each hospital and local government.

The tables below provide an example (based on hypothetical figures) of how the Department will calculate the Assessment Base and Reimbursement Payment for each hospital in the program.

Hospital Provider Assessment Base					
Local Government	**Provider Name**	**Assessment Base (Inflated Inpatient Revenues)**	**Local Assessment Rate**	**Provider's Assessment**	**Local Government Total Assessment Collected**
Government A	Provider A1	$10,000,000	5.5%	$550,000	
	Provider A2	$20,000,000		$1,100,000	$1,650,000
Government B	Provider B1	$20,000,000	4.5%	$900,000	
	Provider B2	$30,000,000		$1,350,000	
	Provider B3	$40,000,000		$1,800,000	$4,050,000
				Total Assessments	$5,700,000

Hospital Reimbursement Payment					
Local Government	**Provider Name**	**Reimbursement Base (Inflated Uncompensated costs)**	**Provider Reimbursement Base as Percent of Local Government Total**	**Local Government Funds Available for Redistribution (Assessment plus Federal Financial Participation)**	**Reimbursement Payment**
Government A	Provider A1	$1,000,000	33.3%	$3,300,000	$1,100,000
	Provider A2	$2,000,000	66.7%		$2,200,000
Total Reimbursement Base Government A		$3,000,000	Total Reimbursement Government A		$3,300,000
Government B	Provider B1	$2,000,000	22.2%	$8,100,000	$1,800,000
	Provider B2	$3,000,000	33.3%		$2,700,000
	Provider B3	$4,000,000	44.4%		$3,600,000
Total Reimbursement Base Government B		$9,000,000	Total Reimbursement Government B		$8,100,000

As an example and using the tables above, Provider A1 in Government A's jurisdiction, has an assessment base of $10,000,000. This amount is multiplied by Government A's local assessment rate of 5.5% which equals $550,000 in assessment fees. Using this same process for the calculation of Provider A2's assessment fee, the Department then sums the

total local government assessment for Government A which equals $1,650,000. This amount will be recorded as Cash Funds Exempt and considered the State match to draw down an equal amount in federal financial participation (subject to the upper payment limits for each provider category). Next, the Department calculates the Reimbursement Payment for each provider and local government. Using the provider's most recent audited Medicare/Medicaid cost report (CMS 2552-96), the Department calculates each provider's unreimbursed Medicaid costs and sums the individual reimbursements to get the total. This total amount is divided into the provider's respective unreimbursed Medicaid cost to calculate the percent of the total unreimbursed Medicaid cost for each local government. This percentage is multiplied by the sum total of the assessment and federal financial participation to produce the provider's total reimbursement payment. The example above also shows that Government B has elected an assessment fee less than the federal Medicaid limit of 5.5%, which is permitted, as each local government may determine its own assessment rate independent of other participating local governments.

The Department used the above methodology to calculate both the Inpatient and Outpatient Reimbursement Payment for Platte Valley Medical Center. For FY 07-08, the Inpatient and Outpatient Reimbursement Payment is $4,225,858 and $5,985,492, respectively. These amounts include the retroactive federal financial participation for FY 06-07. Having submitted the State Plan Amendments on September 29, 2006 and pursuant to 42 CFR §430.20 and §447.256, the Department can seek retroactive federal financial participation effective the first day of the calendar quarter in which the State Plan Amendment was submitted.

For the purposes of estimating the total provider Inpatient and Outpatient Reimbursement Payment for FY 08-09, the Department used the FY 07-08 amounts of $2,154,322 and $3,051,374, respectively, or total funds of $5,205,696. Please see table on page 9.

Consequences if Not Funded:

Pursuant to 25.5-4-417 (2) C.R.S. (2007), the Department is required to amend the Medicaid State Plan to allow the imposition and collection of a provider fee by a local government for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs. Moreover, according to 25.5-4-417 (4) and (5) C.R.S (2007), the

Department is required upon notice of the imposition of a fee by a local government to calculate the unreimbursed Medicaid costs for qualified providers within the participating local government's jurisdiction and distribute the federal financial participation received for eligible unreimbursed Medicaid costs to a local government that has certified payment to qualified providers.

If the request is denied, then the Department will be in violation of the aforementioned State statutes. Furthermore, the Department will lose the opportunity to draw down additional federal financial participation for Colorado hospitals that serve Medicaid clients.

Calculations for Request:

Summary of Request FY 07-08	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Request	$10,211,350	$5,105,675	$5,105,675
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments **(new line item)**	$4,225,858	$2,112,929	$2,112,929
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments **(new line item)**	$5,985,492	$2,992,746	$2,992,746

Summary of Request FY 08-09	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Request	$5,205,696	$2,602,848	$2,602,848
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments **(new line item)**	$2,154,322	$1,077,161	$1,077,161
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments **(new line item)**	$3,051,374	$1,525,687	$1,525,687

Assumptions for Calculations:

The figures used to calculate Platte Valley Medical Center's Inpatient and Outpatient assessment and reimbursement base were taken from the provider's CMS 2552-96 form.

On September 29, 2006, the Department submitted two State Plan Amendments to the Centers for Medicare and Medicaid Services. Having done so allows the Department to seek retroactive federal financial participation effective the first day of the calendar quarter

in which the State Plan Amendment was submitted (42 CFR §430.20 and §447.256). This means that the Department can seek retroactive federal financial participation effective July 1, 2006 based on its State Plan Amendment submission date. Based on these federal Medicaid regulations, the Department can include the FY 06-07 Inpatient and Outpatient provider fees collected in the Department's total funds request for FY 07-08. Please see the table below for the calculation of the FY 06-07 and FY 07-08 Inpatient and Outpatient Hospital Payments.

Calculation of Request Amount for FY 07-08	Total Funds	Cash Funds Exempt	Federal Funds
Total Request	**$10,211,350**	**$5,105,675**	**$5,105,675**
FY 06-07 Inpatient Hospital Payments	$2,071,536	$1,035,768	$1,035,768
FY 06-07 Outpatient Hospital Payments	$2,934,118	$1,467,059	$1,467,059
Total for FY 06-07	**$5,005,654**	**$2,502,827**	**$2,502,827**
FY 07-08 Inpatient Hospital Payments	$2,154,322	$1,077,161	$1,077,161
FY 07-08 Outpatient Hospital Payments	$3,051,374	$1,525,687	$1,525,687
Total for FY 07-08	**$5,205,696**	**$2,602,848**	**$2,602,848**

Calculation of Provider Assessment, Cash Funds Exempt						
Fiscal Year	**Government**	**Provider Name**	**Hospital Service**	**Assessment Base**	**Assessment Rate**	**Provider Assessment**
FY 06-07	City of Brighton	Platte Valley Medical Center	Inpatient	$18,832,147	5.50%	$1,035,768
FY 06-07	City of Brighton	Platte Valley Medical Center	Outpatient	$26,673,799	5.50%	$1,467,059
FY 07-08	City of Brighton	Platte Valley Medical Center	Inpatient	$19,584,733	5.50%	$1,077,160
FY 07-08	City of Brighton	Platte Valley Medical Center	Outpatient	$27,739,759	5.50%	$1,525,687
Total Provider Assessment (may not total correctly due to rounding)						**$5,105,675**

Calculation of Reimbursement Payment, Total Funds						
Fiscal Year	**Government**	**Provider Name**	**Hospital Service**	**Reimbursement Base**	**Provider Reimbursement**	**Provider Reimbursement**

					Base as Percent of Local Government Total	**Available for Redistribution (assessment plus federal funds)**
FY 06-07	City of Brighton	Platte Valley Medical Center	Inpatient	$1,344,534	100.0%	$2,071,536
FY 06-07	City of Brighton	Platte Valley Medical Center	Outpatient	$422,961	100.0%	$2,934,118
FY 07-08	City of Brighton	Platte Valley Medical Center	Inpatient	$1,292,867	100.0%	$2,154,322
FY 07-08	City of Brighton	Platte Valley Medical Center	Outpatient	$406,708	100.0%	$3,051,374
Total Provider Reimbursement Payment						**$10,211,350**

After responding to the January 30, 2007 Request for Additional Information from the Centers for Medicare and Medicaid Services, the Department assumes the Centers for Medicare and Medicaid Services will approve the Department's State Plan Amendments (TN 06-013 and TN 06-014) during the fourth quarter of FY 07-08. Upon approval, the Department will forward the full amount of the Local Government Inpatient and Outpatient Hospital Reimbursement Payment to the City of Brighton by June 30, 2008. Based on State statute (29-28-103 (2) C.R.S. (2007)), the Department must make the Local Government Inpatient and Outpatient Hospital Payments to the participating local governments rather than directly to the individual hospital providers. Additionally, under the same statute, neither the Department nor the local government is allowed to keep any portion of the provider fee or federal financial participation moneys. It is the responsibility of the participating local government to distribute all federal financial participation received for eligible unreimbursed Medicaid costs and all moneys collected from the imposition of provider fees collected to the qualified providers within the local government's jurisdiction. The distribution of federal financial participation and provider fees will be based on the methodology and calculation set forth in Colorado's Medicaid State Plan, Attachment 4.19-A and Attachment 4.19-B.

The Department assumes that the upper payment limit for either inpatient or outpatient services is sufficient to allow all local governments to receive full federal financial participation on the fees collected. If, however, the upper payment limit for either

inpatient or outpatient services is near its limit, then the fees collected by each local government would be reimbursed with federal financial participation at less than a 1:1 ratio.

Since the Department will not receive the provider's most recent audited Medicare/Medicaid cost report(s) until September 1, 2008 for FY 08-09, the Department assumes the total funds request amount for FY 08-09 will be similar to the calculated figures from FY 07-08 of Inpatient and Outpatient Hospital Payments. Furthermore, the Department assumes that the City of Brighton will maintain its provider assessment rate at its current level for FY 08-09 on both Inpatient and Outpatient Hospital Revenues.

The Department will use the following schedule of dates during each State fiscal year to run the program.

Description of task	Date during each fiscal year
Local governments must notify the Department of its intent to impose the Local Government Provider Fee on private hospital providers of inpatient and/or outpatient hospital services.	August 1st
All required hospital providers within the jurisdiction of a participating local government must provide a copy of their most recent audited Medicare/Medicaid cost report (CMS 2552-96) to the Department.	September 1st
The Department will compute and inform participating local governments and private hospitals of allowable fees that may be imposed for inpatient and/or outpatient hospital services within their jurisdictions.	December 1st
The Department will compute the Local Government Inpatient and/or Outpatient Hospital Payment for each qualified provider.	December 15th
The participating local governments must provide documentation that the fee has been assessed and collected.	June 20th
The Department will make final payments to participating local governments.	June 30th
Hospitals must notify the Department of their receipt of payment from the local government.	July 30th

Cost Benefit Analysis:

Description of Benefits	Cost
This is a zero General Fund request and will use the Local Government Provider Fee as Cash Funds Exempt to draw down federal financial participation for unreimbursed Medicaid costs.	$0
The additional federal funds will help Colorado hospitals with their unreimbursed Medicaid costs and avoid cost shifting within the Colorado health care delivery system.	

Implementation Schedule:

Task	Month/Year
Public notice was made concerning the availability of federal financial participation for unreimbursed Medicaid costs	July 2006
[1]Meetings with CMS to Discuss State Plan Amendment and Responses to Request for Additional Information (to obtain feedback from both the CMS Regional Office in Denver and the Home Office in Baltimore)	August 28, 2006 to August 16, 2007
Department submitted State Plan Amendments (TN 06-013 and TN 06-014)	September 29, 2006
Department received Request for Additional Information from CMS	December 6, 2006
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	March 5, 2007
Meeting with City of Brighton and Platte Valley	March 19, 2007
Meeting with Brighton City Council and Platte Valley	May 1, 2007
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	May 16, 2007
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	August 16, 2007
Teleconference with Platte Valley Medical Center (to discuss updated timelines)	August 18, 2007
Department Submits State Plan Amendments and Responses to Request for Additional Information (TN 06-013 and TN 06-014) to CMS for informal review	December 1, 2007
CMS Provides Department with Informal Response	March, 1 2007
Task, continued	**Month/Year**
Department Submits State Plan Amendments and Responses to Request for Additional Information (TN 06-013 and TN 06-014) to CMS for formal review	March 15, 2007

Anticipated approval of State Plan Amendments by Centers for Medicare and Medicaid Services	June 15, 2007
City of Brighton provides documentation that provider fee was assessed and collected	June 20, 2008
Department will make payments to City of Brighton	June 30, 2008
Platt Valley Medical Center will provide the Department with documentation showing receipt of payment from City of Brighton	July 30, 2008

[1]The Department met with CMS to discuss the State Plan Amendments and Requests for Additional Information on several occasions: August 28, 2006; February 22, 2007; April 6, 2007; April 17, 2007; June 14, 2007; and August 16, 2007. The Department met with CMS on these occasions due to the complexity of the State Plan Amendment and also to discuss feedback provided by the CMS Regional Office and their home office in Baltimore, MD.

Statutory and Federal Authority:

29-28-103 (1)(a) C.R.S (2007), Powers of the governing body – fee authorization – unreimbursed Medicaid costs. *The governing body of a local government may impose a fee on a qualified provider located within its territorial boundaries for the purpose of obtaining federal financial participation under the state's medical assistance program, articles 4, 5, and 6 of title 25.5, C.R.S., to reimburse qualified providers for unreimbursed medicaid costs.*

25.5-4-417 (4) C.R.S (2007), Unreimbursed costs – Medicaid providers – state plan amendment – rules. *Upon notice of the imposition of a fee by a local government as authorized by article 28 of title 29, C.R.S., the state department shall calculate the unreimbursed medicaid costs for qualified providers within the local government, excluding any specific costs the local government exempts from the calculation pursuant to section 29-28-103 (1) (b), C.R.S.*

42 C.F.R. §433.68. Permissible health care-related taxes after the transition period. *(a) General rule. Beginning on the day after a State's transition period, as defined in Sec 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.*

Performance Measures:

The Budget Division will maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.